Medicare & You
The knowledge to make good decisions

Medigap Policies and Protections

Supplement Insurance for People with Medicare

This booklet explains . . .

- **Medigap policies and what they cover.**
- **Your rights to buy a Medigap policy when your health coverage changes.**
- **Where to get more help.**

To find out how to use this booklet, see page 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

HCFA
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Health Care Financing Administration

Finding What You Want to Know

Introduction

Medicare does not pay for all of your health care. There are gaps in Original Medicare Plan coverage or costs that you must pay. Medicare supplement insurance policies, or **Medigap policies, are sold by private insurance companies** to help fill the gaps in Original Medicare Plan coverage.

This booklet will give you basic information about Medigap policies and protections you have in certain situations. For the rest of this booklet, Medicare Supplement Insurance Policies will be called Medigap policies.

How to Use This Booklet

This booklet has 6 sections. You can see which section you are reading by the heading at the top of each page. **The index in Section 6 on page 35 can help you find a specific topic in this booklet.** Terms in red are defined in Section 5 on pages 33-34.

If you have questions as you read through this booklet, write them down. Look in Section 4 on pages 31-32 to see who you can call to get help with your questions. **You will not find information about the cost of any Medigap policy in this booklet**. This is because costs will be different depending on where you live and which insurance company you buy the policy from.

Section 1: A Quick Look at Medicare (pages 3-4). Read this section if you don't know much about Medicare. You may need to refer back to it as you read on about Medigap policies and how they work with Medicare.

Section 2: Medigap Policies (pages 5-8). Read this section first if you don't know anything about Medigap policies. It gives you an overview of Medigap policies including how Medigap policies work.

How to Use This Booklet (continued)

Section 3: Medigap Protections (pages 9-29).
Read this section to find out about your rights to buy a Medigap policy in special situations. If you are in a situation where your health coverage has changed, you could have certain rights that you may not know of.

Section 4: Where to Get More Information (pages 30-32).
Read this section to find out where to get more information about Medigap policies in your state. It tells you who to call and gives their phone numbers.

Section 5: Definitions of Important Words (pages 33-34).
Read this section to get the meaning of words in red used in this booklet.

Section 6: Index (page 35).
Use this section if you are looking for a specific topic. It gives you the page(s) where that topic is found in this booklet.

For more detailed information about Medigap policies, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the *Guide to Health Insurance for People with Medicare*, or look at www.medicare.gov on the Internet. You can read or print a copy of the *Guide to Health Insurance for People with Medicare* and compare Medigap policies sold in your state.

Section 1: A Quick Look at Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

What are the two parts of Medicare?

Medicare has two parts:

1. Part A (Hospital Insurance) - Part A helps pay for care in a hospital, some skilled nursing facilities, hospice, and some home health care.

   Most people do not have to pay a monthly payment (premium) for Part A because they (or a spouse) paid Medicare taxes while they were working.

2. Part B (Medical Insurance) - Part B helps pay for doctors, outpatient hospital care, and some other medical services that Part A does not cover, such as the services of physical and occupational therapists, and some home health care.

   You pay the Medicare Part B premium of $45.50 per month in 2000. Rates can change yearly. In some cases, this amount may be higher if you did not choose Part B when you first became eligible for Medicare.

For more information about Medicare Part A and Part B, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of *Medicare & You*.

Remember, terms in red are defined in Section 5 on pages 33-34.

What are my Medicare health plan choices?

Depending on where you live, you may have three choices:

1. The Original Medicare Plan (also known as fee-for-service),

2. Medicare Managed Care Plans (like an HMO), or

3. Private Fee-for-Service Plans (a new health care choice that will become available in some areas of the country in 2000).

Note: Medigap policies only help pay health care costs if you have the Original Medicare Plan.

For more information about your Medicare health plan choices, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired).

What is a Medigap policy and how does it work?

*Call your State Insurance Department for more information on the policies that are offered in these states. You can also look on the Internet at www.medicare.gov and click on "Medigap Compare."

"The thing about Medigap is you can take as much or as little coverage as you want. When I had knee surgery, my Medigap policy (Plan F) paid many of the costs that Medicare did not pay for."

Mark
Providence,
Rhode Island

A Medigap policy is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. The front of the Medigap policy must clearly identify it as "Medicare Supplement Insurance." In all but three states (Massachusetts, Minnesota, and Wisconsin)*, there are 10 standardized Medigap plans called "A" through "J." Each plan has a different set of standard benefits.

When you buy a Medigap policy, you pay a premium to the insurance company. As long as you pay your premium, policies bought after 1990 are automatically renewed each year. This means that your coverage continues year after year as long as you pay your premium. You still must pay your monthly Medicare Part B premium.

Medicare SELECT

Medicare SELECT is a type of Medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans "A" through "J." With a Medicare SELECT policy, you need to use specific hospitals and doctors to get full insurance benefits (except in an emergency). For this reason, Medicare SELECT policies generally have lower premiums.

If you don't use a Medicare SELECT provider for non-emergency services, you will have to pay what Medicare doesn't pay. Medicare will pay its share of approved charges no matter what provider you choose. Medicare SELECT might not be offered in your state.

For more information, call your State Health Insurance Assistance Program (see pages 31-32).

What do Medigap policies pay for?

Each standardized Medigap policy must cover basic benefits (see the chart on page 7). Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance amounts. These policies may also cover the Original Medicare Plan deductibles. Some of the policies cover extra benefits to fill more of the gaps in your coverage, like prescription drugs (see page 8).

If you live in Massachusetts, Minnesota, or Wisconsin, call your State Insurance Department (see pages 31-32) for more information on the policies that are offered in these states. You can also look on the Internet at www.medicare.gov and click on "Medigap Compare."

What is not paid for by Medigap policies?

Medigap policies do not cover:

- Long-term care
- Vision or dental care
- Hearing aids
- Private-duty nursing
- Unlimited prescription drugs

What should I think about before buying a Medigap policy?

Before buying a Medigap policy, think about:

- How much am I spending on health care?
- What are my health care dollars spent on?
- Which Medigap benefits do I need?
- How much can I afford to spend on premiums?
- What will my future health care costs be? Remember, you may need more health care as you get older.

Remember, terms in red are defined in Section 5 on pages 33-34.

Chart of Ten Standardized Medigap Plans A through J

Medigap policies (including Medicare SELECT) can only be sold in 10 standardized plans. This chart gives you a quick and easy look at all the Medigap plans and what benefits are in each plan.

Basic Benefits: Included in All Plans.

- **Inpatient Hospital Care:** Covers the Part A coinsurance and for the cost of 365 extra days of hospital care during your lifetime after Medicare coverage ends.
- **Medical Costs:** Covers the Part B coinsurance (generally 20% of the Medicare-approved payment amount).
- **Blood:** Covers the first 3 pints of blood each year.

A	B	C	D	E	F*	G	H	I	J*
Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit	Basic Benefit
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drug Benefit ($1,250 Limit)	Basic Drug Benefit ($1,250 Limit)	Extended Drug Benefit ($3,000 Limit)
				Preventive Care					Preventive Care

* Plans F and J also have a high deductible option (see page 8). Call your State Insurance Department for more information (see pages 31-32). **Note:** This chart does not apply if you live in Massachusetts, Minnesota, or Wisconsin. Call your State Insurance Department (see pages 31-32) for more information on the policies that are offered in these states. You can also look on the Internet at www.medicare.gov and click on "Medigap Compare."

Do any Medigap policies pay for prescription drugs?

Yes. Plans H and I offer the "basic" prescription drug benefit. Plan J offers the "extended" prescription drug benefit (see the chart below).

	After you pay . . .	The plan pays . . .
Plans H and I ▶ **Basic Prescription Drug Coverage**	$250 per year deductible	50% of prescription drug costs up to a maximum of **$1,250** per year.
Plan J ▶ **Extended Prescription Drug Coverage**	$250 per year deductible	50% of prescription drug costs up to a maximum of **$3,000** per year.

What is a "high deductible option" and how does it affect my costs?

Insurance companies may offer a "high deductible option" on Plans F and J. If you choose this option, you must pay a $1,530 deductible for the year 2000 before the plan pays anything. This is an increase for all high deductible plans that were bought before 2000. This amount may go up each year.

High deductible option policies often cost less but, if you get sick, your out-of-pocket costs will be higher and you may not be able to change plans.

In addition to the $1,530 deductible that you must pay for the high deductible option on plans F and J, you must pay deductibles for:

- Prescription drugs ($250 per year for Plan J), and
- Foreign travel emergency ($250 per year for Plans F and J).

What are Medigap protections?

Medigap protections are special rights you have to buy a Medigap policy in addition to your Medigap open enrollment period. These protections are important because if you do not buy a Medigap policy during your Medigap open enrollment period, you may not be able to buy the one you want, or you may be charged more for the policy. In addition, if you drop your Medigap policy, you may not be able to get it back unless you have this protection.

The Medigap protections in this section are from federal law. Some states provide more Medigap protections than federal law. At the time this booklet was printed, these states reported that they offer more Medigap protections than federal law:

- Arkansas
- Delaware
- Florida
- Iowa
- Illinois
- Indiana
- Kansas
- Maine
- Massachusetts
- North Carolina
- New Hampshire
- New Mexico
- Nevada
- New York
- South Dakota
- Texas
- Vermont
- Wisconsin
- West Virginia
- Wyoming

Call your State Insurance Department (see pages 31-32) or State Health Insurance Assistance Program (see pages 31-32) to find out if your state offers more Medigap protections than federal law.

When do I have a right to Medigap protections?

There are a few types of situations involving health coverage changes where you may have a guaranteed issue right to buy a Medigap policy even when you are not in your Medigap open enrollment period.

For example:

1. Your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area (see Situation #1 on pages 11-15), or

2. Your health coverage (like a Medicare managed care plan or Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, Program of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends through no fault of your own, including your moving outside of the plan's service area (see Situation #2 on pages 15-18), or

3. You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy for the first time, and then leave the plan or policy within one year after joining (see Situation #3 on pages 19-22), or

4. You joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or Private Fee-for-Service plan) when you first became eligible for Medicare at age 65 and within one year of joining, you decided to leave the health plan (see Situation #4 on pages 23-25).

Situations 1 through 4 will be discussed in detail on the following pages.

Do you live in Massachusetts, Minnesota, or Wisconsin?

If so, you have the right to buy a Medigap policy that is similar to the standardized policies you have a right to buy in the other states. Call your State Insurance Department (see pages 31-32).

Remember, terms in red are defined in Section 5 on pages 33-34.

Situation #1 ▶

Your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area.

If your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area, you have the right to buy Medigap plans A, B, C, or F that are sold in your state.

In some cases, you have the right to return to your old Medigap policy (see Situation #3 on pages 19-22) or to buy **any** of the 10 standardized Medigap policies sold in your state (see Situation #4 on pages 23-25).

If you get a letter telling you that your Medicare managed care plan or Private Fee-for-Service plan is leaving the Medicare program or will no longer give care in your area, you have 3 choices:

1. **Stay in your plan until the date your coverage ends.** You have 63 calendar days after your health coverage ends to apply for a Medigap policy.

2. **Switch to another Medicare managed care plan in your area.** In some cases, you may have to wait until the new plan is accepting new members to join.

3. **Leave your plan (disenroll) as soon as you get your letter.** You have 63 calendar days from the date on the letter from your Medicare managed care plan or Private Fee-for-Service plan telling you that the plan will no longer be giving care in your area, to apply for a Medigap policy.

Choice #3 only applies to Private Fee-for-Service plans or Medicare managed care plans with a "Medicare + Choice" contract (not a "cost contract").

Situation #1 (continued) ▶

Call your managed care plan to find out if it has a Medicare+Choice contract. If it does, you can leave the plan as soon as you get your letter without losing your Medigap protections.

You have the right to buy Medigap plans A, B, C, or F that are sold in your state. If you decide to leave your plan before your coverage ends, you must turn in a **written** request to your plan telling them you want to leave (disenroll). Your coverage will end on the last day of the month in which your plan gets your written request to leave (see Example #1a below).

Example #1a:

In October 2000, Mrs. Walton receives a letter from her Medicare managed care plan (with a Medicare+Choice contract) telling her that the plan will be leaving the Medicare program on December 31, 2000. The letter is dated October 1, 2000. She decides to get health care coverage from the Original Medicare Plan. She turns in her written request to leave her plan on October 12, 2000. Her coverage will end October 31, 2000. Mrs. Walton has the right to buy Medigap plans A, B, C, or F that are sold in her state as long as she applies by December 2, 2000 (63 calendar days from the date on the plan's letter to her).

Situation #1 (continued) ▶

As long as you apply for your new Medigap policy no later than 63 calendar days from the date on the letter from your plan or no later than 63 calendar days after your health coverage ends (see Example #1b below), the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (such as making you wait for coverage to start);
- Must cover you for all pre-existing conditions;
- Cannot charge you more for a policy because of past or present health problems.

Example #1b:

In October 2000, Mrs. Walton receives a letter from her Medicare managed care plan telling her that it will be leaving the Medicare program on December 31, 2000. The letter is dated October 1, 2000. She decides to stay in her plan until her coverage ends on December 31, 2000. She will automatically be enrolled in the Original Medicare Plan starting January 1, 2001. Mrs. Walton has the right to buy Medigap plans A, B, C, or F that are sold in her state as long as she applies by March 4, 2001 (63 calendar days after her health coverage ends).

Important: When your health coverage ends, your health plan will send you a letter telling you that your coverage is ending. Keep a copy of the letter (make sure that your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a dated copy of your Medigap policy application, and any insurance company denial letters that are mailed to you, to prove that you have been denied your Medigap rights if this happens.

Remember, terms in red are defined in Section 5 on pages 33-34.

Situation #1 (continued) ▶

Does this protection cover me if I am under age 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD)?

There is no federal law that requires insurance companies to have general Medigap open enrollment periods for people under age 65. However, if any insurance company in your state sells Medigap plans A, B, C, or F to people under age 65, either voluntarily or because it is required by state law, they must sell you a policy if you are in situation #1, #2, or #3 listed on page 10. Call your State Health Insurance Assistance Program for more information (see pages 31-32).

Summary of your Medigap protections if your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area:

- You may have 3 choices about what to do, and when to do it (see page 11);
- You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days from the date on the letter from your plan or no later than 63 calendar days after your health coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (such as making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems;
- If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are otherwise sold in your state to people under age 65 with Medicare.

Situation #1 (continued) ▶

Remember, if you wish to leave the plan as soon as you get your letter, you should first call your managed care plan to find out if it has a Medicare+Choice contract rather than a "cost contract." If it does, you can leave the plan as soon as you get your letter without losing your Medigap protections.

Another Option

Even if you do not meet the conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 31-32).

Situation #2 ▶

Your health coverage ends through no fault of your own, including your moving outside of the plan's service area.

If your health coverage (like a Medicare managed care plan, Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, Program of All-Inclusive Care for the Elderly (PACE), or Medicare managed care demonstration project) ends, in certain situations you have the right to buy Medigap plans A, B, C, or F that are sold in your state. You must apply no later than 63 calendar days after your health coverage ends.

The insurance company must sell you one of these Medigap plans if:

- You move outside of the plan's service area (the area where the plan accepts members and where you get services from the plan); or
- You leave the health plan because it failed to meet its contract obligations to you (for example, the marketing material was misleading or quality standards were not met); or
- You were in an employer group health plan that supplemented or paid some of the costs not paid for by Medicare, and the plan ends your coverage; or

Remember, terms in red are defined in Section 5 on pages 33-34.

Situation #2 (continued) ▶

- Your insurance company ends your Medicare SELECT policy and you're not at fault (for example, the company goes bankrupt); or
- Your PACE program stops participating in Medicare or stops giving care in your area.

As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- Must cover you for all pre-existing conditions;
- Cannot charge you more for a policy because of past or present health problems.

You should not wait until your health coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage (see Example #2 on page 17).

Caution: In most cases in Situation #2, you must stay in your health plan until the date your coverage ends. If you leave the plan before that date, you may lose your right to buy Medigap plans A, B, C, or F that are sold in your state.

Situation #2 (continued) ▶

Example #2:

Mrs. Jones was covered under an employer group health plan that paid some of the costs not paid for by Medicare. She got a letter in the mail telling her that her health plan coverage was ending on April 5, 2000. Mrs. Jones wanted to buy a Medigap policy that would help pay her health care costs not covered by Medicare. Because her health care coverage was ending, Mrs. Jones had the right to buy Medigap plans A, B, C, or F that were sold in her state as long as she applied by June 7, 2000 (63 calendar days after her health coverage ended). She had to stay in her employer group health plan until the date her coverage ended, or she would lose her right to buy one of these Medigap plans. Mrs. Jones applied for a Medigap policy on March 16, 2000 and chose to start her Medigap coverage on April 6, 2000, the day after her health coverage ended. This prevented gaps in her health coverage.

Important: When your health coverage ends, your health plan will send you a letter telling you that your coverage is ending. Keep a copy of the letter (make sure that your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a dated copy of your Medigap policy application, and any insurance company denial letters that are mailed to you, to prove that you have been denied your Medigap rights if this happens.

Does this protection cover me if I am under age 65 and have Medicare because of a disability or End-Stage Renal Disease (ESRD)?

There is no federal law that requires insurance companies to sell Medigap plans to people under age 65. However, if any insurance company in your state

Situation #2 (continued) ▶

sells Medigap plans A, B, C, or F to people under age 65, either voluntarily or because it is required by state law, they must sell you a policy if you are in situations #1, #2, or #3 listed on page 10. Call your State Health Insurance Assistance Program for more information (see pages 31-32).

Summary of your Medigap protections if your health coverage ends through no fault of your own, including your moving outside of the plan's service area (see page 15):

- You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your health coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems;
- If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are otherwise sold in your state to people under age 65 with Medicare.

Another Option

Even if you do not meet the conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 31-32).

Situation #3 ▶

You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy for the first time, and then leave the plan or policy within one year after joining.

If you dropped your Medigap policy to join a Medicare health plan (like a Medicare managed care plan or a Private Fee-for-Service plan) or buy a Medicare SELECT policy, and then leave the plan or policy, under certain conditions, you may be able to return to the Medigap policy you had before (if it is still available).

You have this protection, if:

- This is the first time that you have ever been enrolled in a Medicare health plan or Medicare SELECT policy; and
- You leave the Medicare health plan or Medicare SELECT policy within one year after joining.

You must apply for your former Medigap policy no later than 63 calendar days after your Medicare health plan coverage ends (see Example #3 on page 21). If your former Medigap policy is no longer available, see "What can I do if the Medigap policy I had is no longer available?" on page 20.

Remember, you should not wait until your Medicare health plan coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your Medicare health plan) and choose to start your Medigap coverage the day after your health plan coverage ends. This will prevent gaps in your health coverage (see Example #3 on page 21).

Remember, terms in red are defined in Section 5 on pages 33-34.

Situation #3 (continued) ▶

Important: If you bought a Medigap policy before 1990, your policy is not a standardized Medigap policy. It may have benefits that are different from the 10 standardized Medigap plans. Therefore, if you dropped it, you would not be able to get it back because that policy is no longer being sold.

What can I do if the Medigap policy I had is no longer available?

If your former Medigap policy is no longer available, you have the right to buy Medigap plans A, B, C, or F from any insurance company which sells these plans in your state. You must apply no later than 63 calendar days after your Medicare health plan coverage ends. As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- Must cover you for all pre-existing conditions;
- Cannot charge you more for a policy because of past or present health problems.

Important information about Medicare SELECT policies:

You may also have this same protection if you dropped a Medicare SELECT policy to join a Medicare health plan (like a Medicare managed care plan). This is because a Medicare SELECT policy is a type of Medigap policy.

Situation #3 (continued) ▶

If you currently have a Medicare SELECT policy, you also have the right to switch, at any time, to a regular Medigap policy that is sold by the same company (if any are available). The Medigap policy you switch to must have equal or less coverage than the Medicare SELECT policy you currently have.

Example #3:

Mr. Perkins joined a Medicare managed care plan on December 1, 2000. He had never been in a Medicare managed care plan before. Before that, Mr. Perkins was in the Original Medicare Plan and had a Plan J Medigap policy. Six months later, Mr. Perkins decided to leave the managed care plan and return to the Original Medicare Plan. He put in his request in writing to leave his managed care plan on June 5, 2001. His managed care plan coverage ended on June 30, 2001. Because this was the first time he had ever been in a Medicare managed care plan, he had the option of returning to his Plan J Medigap policy as long as he applied for it by September 1, 2001 (63 calendar days after his health coverage ended). Mr. Perkins found out that his Medigap insurance company still sold Medigap policy Plan J. He applied for it on June 10, 2001, and chose to start his Medigap coverage on July 1, 2001, the day after his Medicare health plan coverage ended. This prevented gaps in his health coverage.

Situation #3 (continued) ▶

Summary of your Medigap protections if you dropped your Medigap policy to join a Medicare health plan (like a Medicare managed care plan or Private Fee-for-Service plan) or buy a Medicare SELECT policy for the first time, then leave the plan or policy within one year after joining:

- You have the right to return to your former Medigap policy (if it is still available from the same insurance company). You must apply no later than 63 calendar days after your Medicare health plan coverage ends;
- If your former policy is not available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems.

Another Option

Even if you do not meet the conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 31-32).

Situation #4 ▶

You joined a Medicare health plan (like a Medicare managed care plan with a Medicare+Choice contract or a Private Fee-for-Service plan) when you first became eligible for Medicare at age 65*, and within one year after joining, you decided to leave the health plan.

In this situation, you have the right to buy **any** Medigap policy sold in your state.

This only applies to Private Fee-for-Service plans or Medicare managed care plans with a Medicare+Choice contract. Call your managed care plan to find out if they have a Medicare+Choice contract.

You must apply for the Medigap policy no later than 63 calendar days after your Medicare health plan coverage ends. As long as you apply for your new Medigap policy no later than 63 calendar days after your health coverage ends, the insurance company:

- Cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- Must cover you for all pre-existing conditions;
- Cannot charge you more for a policy because of past or present health problems.

You should not wait until your Medicare health plan coverage has almost ended before you apply for a Medigap policy. You can apply for a Medigap policy early (while you are still in your Medicare health plan) and choose to start your Medigap coverage the day after your Medicare health plan coverage ends. This will prevent gaps in your health coverage (see Example #4 on page 24).

*You are eligible for Medicare on the first day of the month in which you turn age 65. If your birthday is on the first day of the month, your Medicare coverage starts on the first day of the month before your birthday.

Remember, terms in red are defined in Section 5 on pages 33-34.

Situation #4 (continued) ▶

Note: If you are still in your 6-month Medigap open enrollment period after you leave your Medicare health plan, you may have more than 63 calendar days to buy a Medigap policy. Call your State Health Insurance Assistance Program for more information (see pages 31-32).

Example #4:

Mrs. Miner joined a Medicare managed care plan on February 1, 2000, the first day of the month in which she turned 65. Six months later, she decided to leave her plan. She turned in her written request to leave her plan on August 3, 2000. Her managed care plan coverage ended on August 30, 2000. Since she did not choose to join another managed care plan, she was automatically enrolled in the Original Medicare Plan. Mrs. Miner had the right to buy any Medigap policy, as long as she applied by November 2, 2000 (63 calendar days after her health coverage ended). Mrs. Miner applied for her Medigap policy on August 25, 2000, and chose to start her Medigap coverage on September 1, 2000, the day after her Medicare health plan coverage ended. This prevented gaps in her health coverage.

Situation #4 (continued) ▶

Summary of Medigap protections when you joined a Medicare health plan (like a Medicare managed care plan with a Medicare + Choice contract or a Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and within one year after joining you decided to leave the health plan:

- You have the right to buy **any** Medigap policy sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends;
- The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start);
- The insurance company must cover you for all pre-existing conditions;
- The insurance company cannot charge you more for a policy because of past or present health problems.

Another Option

Even if you do not meet the conditions for Medigap protections, your insurance company may still allow you to buy any Medigap policy, especially if you are in good health. For more information, call your State Health Insurance Assistance Program (see pages 31-32).

Adding It All Up

If you think any of the situations in this section apply to you, you may have the right to buy a Medigap policy. Call your State Health Insurance Assistance Program (see pages 31-32) to make sure that you qualify for these Medigap protections. They can also help you find the Medigap policy that is right for you.

Important: When your health coverage ends (see Situation #1 on page 11 and Situation #2 on page 15), your health plan will send you a letter telling you that your coverage is ending. Keep a copy of the letter (make sure your name is on the letter) and the postmarked envelope to prove that you lost coverage from your health plan. You should also keep a copy of your dated Medigap policy application, and any insurance company denial letters that are mailed to you, to prove that you have been denied your Medigap rights if this happens.

If you are denied Medigap coverage, call your State Insurance Department (see pages 31-32).

Remember, to get these protections, you must apply no later than 63 calendar days after your health coverage ends.

Summary of Medigap Protections Chart

The following chart is a summary of the situations, explained on the previous pages, that may give you the right to buy a Medigap policy when your health coverage changes, and the protections that apply for each situation. In order to get these Medigap protections, you must meet certain conditions. See the following chart for more details. If you live in Massachusetts, Minnesota, or Wisconsin, you have the right to buy a Medigap policy that is similar to the standardized policies you have the right to buy in the other states. Call your State Insurance Department (see pages 31-32).

Note: There may be times when more than one of these situations apply to you. When this happens, you may want to choose the protection that gives you the best choice of policies. For example, if both situations #1 and #4 apply to you, you may have the right to buy any Medigap policy. This is because situation #4 offers you the best choice by allowing you to buy any Medigap policy that is sold in your state. Situation #1 limits your choices to only Medigap plans A, B, C, or F that are sold in your state.

Your Health Coverage Situation	Medigap Protections
1. Your Medicare managed care plan or Private Fee-for-Service plan coverage ends because the plan is leaving the Medicare program or stops giving care in your area.	You may have 3 choices. (For more information on these 3 choices, see page 11.) You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after you get your letter from your plan (for Medicare health plans with a Medicare+Choice contract) or no later than 63 calendar days after your health coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare. Remember, there is no federal law that requires insurance companies to sell Medigap plans to people under age 65.

Your Health Coverage Situation	Medigap Protections
2. Your health coverage (like a Medicare managed care plan or Private Fee-for-Service plan, employer group health plan that supplemented or paid some of the costs not paid for by Medicare, Medicare SELECT policy, Program of All-Inclusive Care for the Elderly (PACE), or a Medicare managed care demonstration project) ends through no fault of your own, including your moving outside of the plan's service area.	You have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your health coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. If you are under age 65 and have Medicare because of a disability or ESRD, you must be allowed to buy Medigap plans A, B, C, or F that are sold in your state to people under age 65 with Medicare. **Caution:** In most cases, you must stay in your health plan until the date your coverage ends. If you leave the plan before this date, you may lose your right to buy Medigap plans A, B, C, or F.

Your Health Coverage Situation	Medigap Protections
3. You dropped your Medigap policy to join a Medicare managed care plan or Private Fee-for-Service plan, or buy a Medicare SELECT policy, then leave the plan or policy, and: ■ This is the first time that you have ever been enrolled in a Medicare health plan or Medicare SELECT policy; and ■ You leave the Medicare health plan or Medicare SELECT policy within one year after joining.	You must be allowed to return to your former Medigap policy if it is still available from the same insurance company. You must apply no later than 63 calendar days after your health coverage ends. If it is not available, you have the right to buy Medigap plans A, B, C, or F that are sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. **Caution:** If you bought a Medigap policy before 1990, your policy is probably not a standardized Medigap policy. It may have benefits that are different from the 10 standardized Medigap plans. Therefore, if you dropped it, you would not be able to get it back because that policy is no longer being sold.
4. You joined a Medicare health plan (like a Medicare managed care plan with a Medicare+Choice contract or a Private Fee-for-Service plan) when you first became eligible for Medicare at age 65, and within one year after joining, you leave the health plan.	You must be allowed to buy **any** Medigap policy sold in your state as long as you apply no later than 63 calendar days after your Medicare health plan coverage ends. The insurance company cannot deny you insurance coverage or place conditions on the policy (like making you wait for coverage to start). You must be covered for all pre-existing conditions. You can't be charged more for a policy because of past or present health problems. **Note:** If you are still in your Medigap open enrollment period after you leave your Medicare health plan, you may have more than 63 calendar days to buy a Medigap policy.

All rights to buy Medigap policies under these protections include Medicare SELECT policies since they are a type of Medigap policy.

How can I get information on Medigap policies in my state?

You can get information about Medigap policies in your state by calling:

- Your State Insurance Department to find out what Medigap polices are available in your state and which companies sell them (see pages 31-32)*; or
- Your State Health Insurance Assistance Program to get free counseling to help you decide which policy is best for you (see pages 31-32)*.

You can also find information on Medigap policies offered in your state and compare them at www.medicare.gov on the Internet. Click on "Medigap Compare." This website has information on:

- Which Medigap policies are sold in your state.
- How to shop for a Medigap policy.
- What the policies must cover.
- How insurance companies decide what to charge you for a Medigap policy premium.
- Your Medigap rights and protections.

If you don't have a computer, your local library or senior center may be able to help you look at this information.

For more detailed information about Medigap policies, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) and ask for a free copy of the *Guide to Health Insurance for People with Medicare*, or look at www.medicare.gov on the Internet. You can read or print a copy of the *Guide to Health Insurance for People with Medicare* and compare Medigap policies sold in your state.

*At the time of printing, phone numbers listed were correct. Phone numbers sometimes change. To get the most updated phone numbers, call 1-800-MEDICARE (1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired) or look on the Internet at www.medicare.gov and click on "Helpful Contacts."

State	State Department of Insurance	State Health Insurance Assistance Program
Alabama	(334) 241-4101	(334) 242-5743
Alaska	(907) 269-7900	(907) 269-3680
American Samoa	(808) 586-2790	(808) 586-7299
Arizona	(602) 912-8444	(800) 432-4040
Arkansas	(800) 224-6330	(800) 224-6330
California	(213) 897-8921	(800) 434-0222
Colorado	(303) 894-7499	(303) 894-7499 ext. 356
Connecticut	(860) 297-3800	(860) 424-5245
Delaware	(302) 739-6775	(302) 739-6266
Florida	(850) 922-3100	(850) 414-2060
Georgia	(404) 656-2070	(404) 657-5334
Guam	(808) 586-2790	(808) 586-7299
Hawaii	(808) 586-2790	(808) 586-7299
Idaho	(208) 334-4250	(208) 334-4350
Illinois	(312) 814-2427	(217) 785-9021
Indiana	(317) 232-2395	(800) 452-4800
Iowa	(515) 281-5705	(800) 351-4664
Kansas	(785) 296-3071	(316) 337-7386
Kentucky	(800) 595-6053	(502) 564-7372
Louisiana	(225) 342-5301	(225) 342-0825
Maine	(207) 624-8475	(800) 750-5353
Maryland	(800) 492-6116	(410) 767-1100
Massachusetts	(617) 521-7794	(617) 727-7750
Michigan	(877) 999-6442	(800) 803-7174
Minnesota	(651) 296-4026	(800) 333-2433
Mississippi	(601) 359-3569	(800) 948-3090
Missouri	(800) 726-7390	(800) 390-3330
Montana	(406) 444-2040	(406) 444-7781
Nebraska	(800) 234-7119	(800) 234-7119
Nevada	(775) 687-4270	(800) 307-4444

State	State Department of Insurance	State Health Insurance Assistance Program
New Hampshire	(800) 852-3416	(603) 225-9000
New Jersey	(609) 292-5360	(609) 588-3139
New Mexico	(505) 827-4601	(505) 827-7640
New York	(212) 480-6400	(800) 333-4114
North Carolina	(919) 733-0111	(919) 733-0111
North Dakota	(701) 328-2440	(701) 328-2440
Ohio	(614) 644-2673	(614) 644-3458
Oklahoma	(405) 521-2828	(405) 521-6628
Oregon	(503) 947-7984	(503) 947-7984
Pennsylvania	(717) 787-2317	(800) 783-7067
Puerto Rico	(787) 722-8686	(787) 721-8590
Rhode Island	(401) 222-2223	(401) 222-2880
South Carolina	(803) 737-6180	(803) 898-2850
South Dakota	(605) 773-3563	(605) 773-3656
Tennessee	(800) 525-2816	(800) 525-2816
Texas	(800) 252-3439	(800) 252-9240
Utah	(801) 538-3805	(801) 538-3910
Vermont	(802) 828-2900	(800) 642-5119
Virgin Islands	(340) 774-7166	(340) 778-6311 ext. 2338
Virginia	(804) 371-9691	(800) 552-3402
Washington	(800) 397-4422	(800) 397-4422
Washington D.C.	(202) 727-8000	(202) 676-3900
West Virginia	(304) 558-3386	(877) 987-4463
Wisconsin	(608) 266-3585	(877) 333-0202
Wyoming	(307) 777-7401	(800) 856-4398

Coinsurance
The percent of the Medicare-approved amount that you have to pay after you pay the deductible for Part A and/or Part B. In the Original Medicare Plan, the coinsurance payment is a percentage of the cost of the approved amount for the service (like 20%).

Copayment
In some Medicare health plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor visit. Copayments may also be used for hospital outpatient services in the Original Medicare Plan starting later in the year 2000.

Deductible
The amount you must pay for health care, before Medicare or some Medigap policies begin to pay. Some Medicare deductibles can change every year.

Employer Group Health Plan
A health plan that:
1. gives health coverage to employees, former employees, and their families, and
2. is from an employer or employee organization.

End-Stage Renal Disease (ESRD)
Permanent kidney failure that is severe enough to require lifetime dialysis or a kidney transplant.

Excess Charges
The difference between a doctor's or other health care provider's actual charge (which may be limited by Medicare or the state) and the Medicare-approved payment amount.

Guaranteed Issue Rights
A right you have in certain situations when insurance companies are required by law to issue you a Medigap policy.

Medicare-Approved Amount
The fee Medicare sets as reasonable for a covered medical service. This is the amount a doctor or supplier is paid by you and Medicare for a service or supply. It may be less than the actual amount charged by a doctor or supplier. The approved amount is sometimes call the "Approved Charge."

Medicare Managed Care Plans
These are health care choices in some areas of the country. In most plans, you can only go to doctors, specialists, or hospitals on the plan's list. Plans must cover all Medicare Part A and Part B health care. Some plans cover extras like prescription drugs. Your costs may be lower than in the Original Medicare Plan.

Open Enrollment Period
A one time only, 6-month period after you enroll in Medicare Part B and are age 65 or older, when you can buy any Medigap policy you want. During this time, you cannot be denied coverage or charged more due to your history.

Original Medicare Plan
A pay-per-visit health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Pre-existing Condition
A health problem for which you got medical treatment or advice within 6 months of the date that a new insurance policy starts.

Premium
What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Private Fee-for-Service Plan
A private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much you pay for the services you get. You may pay more for Medicare-covered benefits. You may have extra benefits the Original Medicare Plan does not cover.

Program of All-Inclusive Care for the Elderly (PACE)
PACE is a special program that combines both outpatient and inpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent and living in your community as long as possible, and to provide quality care at low cost.

Section 6: Index

NOTES

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES

Health Care Financing Administration
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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